PRINTED: 11/10/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		345492	B. WING				C
NAME OF D		343492	D. WING		FREET ARRESTON OFFICE TIP CORE	11/	04/2022
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
NC STATE	VETERANS HOME - FA	YETTEVILLE			4 COCHRAN AVENUE		
				FA	AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	on 11/4/22. A focused was conducted. The focused compliance with 42 C	ered on 11/1/22 and exited I infection control survey facility was found to be in FR §483.73 related to rt-B-Requirements for Long					
F 000	INITIAL COMMENTS		F	000			
	to conduct a complair infection control surve onsite 11/1/22 to 11/3 to be in compliance winfection control regul the CMS and Centers Prevention (CDC) recoprepare for COVID-19. The following intakes NC00192599, NC001	ations and has implemented of for Disease Control and commended practices to 9. Event ID# B7Y611 were investigated: 93906, and NC00192121. Illegations was substantiated					
	CFR 483.25 at tag F6 The tag F684 constitu	was identified at: 680 at a scope and severity J 684 at a scope and severity J uted Substandard Quality of					
F 580 SS=J	facility came back in a 10/29/22. A Partial exconducted on 11/4/22 date was changed to	xtended survey was 2. Therefore, the survey exit 11/4/22. jury/Decline/Room, etc.)	F	580			
LABORATORY	DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION  NG	(X:	3) DATE SURVEY COMPLETED
		345492	B. WING			C
	ROVIDER OR SUPPLIER	l	B. WING	STREET ADDRESS, CITY, STATE, ZIE 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301	PCODE	11/04/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 580	§483.10(g)(14) Notificity A facility must immonsult with the residence consistent with his or representative(s) where (A) An accident involvesults in injury and head of the physician intervention (B) A significant charmental, or psychosocideterioration in health status in either life-th clinical complications (C) A need to alter the aneed to discontinue treatment due to advommence a new for (D) A decision to transident from the facility when making not (14)(i) of this section, all pertinent informatics available and proviphysician.  (iii) The facility must resident and the resi	cation of Changes. nediately inform the resident; nent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; nge in the resident's physical, has tatus (that is, a h, mental, or psychosocial reatening conditions or n); heatment significantly (that is, he an existing form of herse consequences, or to m of treatment); or his sfer or discharge the hit as specified in his fication under paragraph (g) he facility must ensure that hon specified in §483.15(c)(2) heded upon request to the halso promptly notify the heatent representative, if any, heaten or roommate assignment his corroommate assignmen	F	580		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345492	B. WING			1	04/2022
	ROVIDER OR SUPPLIER			21	TREET ADDRESS, CITY, STATE, ZIP CODE  14 COCHRAN AVENUE  AYETTEVILLE, NC 28301	1 11/	04/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	that is a composite di §483.5) must disclose its physical configurar locations that compris part, and must specificate room changes between under §483.15(c)(9). This REQUIREMENT by:  Based on record reviphysician interview for sampled residents with the facility failed to not resident had fallen or Failure to notify the plassessment and identify the left maxillary sit of the left	posite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations  T is not met as evidenced sew, staff interview, and er one (Resident # 3) of three no experienced accidents, butify the physician that the enthe date on which he fell. The hysician resulted in delayed tification of multiple facial ent # 3 sustained from the included fracture of the wall mus (near the nose), fracture the jawbone), fracture of the east (which allows the le eating), and fracture of rim and lateral orbital wall ee).  E at the facility from 11/5/21 ent # 3's diagnoses included ewy Body Dementia, ike uncontrolled body overments caused by a ).  tes for 9/27/22 revealed the dat 6:28 PM. Nurse # 1	F	089	Past noncompliance: no plan of correction required.		

PRINTED: 11/10/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345492	B. WING			I	04/2022
	ROVIDER OR SUPPLIER	L		2	STREET ADDRESS, CITY, STATE, ZIP CODE 14 COCHRAN AVENUE 5AYETTEVILLE, NC 28301	1 11/4	04/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Took meds crushed in Cal. No S/S (signs and discomfort. Incontinenthigh risk for falls r/t (rubody movement. Was nurse and ADON (Asthat resident has bruis laceration to left cheethis cheek because of movements. He is no along left jaw line. He pain. DOHS (Director provider notified."  The next nursing entreficial of the confusion noted. Bed I call bell within reach. with confusion noted. active (bleeding) to latine, discoloration to legist (signs and sympostation of the confusion noted). The next nursing entregist (signs and sympostation of the confusion noted) active (bleeding) to latine, discoloration to legist (signs and sympostation of the confusion noted). The next nursing entregist (signs and sympostation of the confusion	ntrollable body movements. In apple sauce. Drank Two Ind symptoms) pain or Int urine X 1. Remains very Idelated to) uncontrollable Is informed by off going Is isstant Director of Nursing) Is ing to left orbit and a small Is is from probably bumping Is is uncontrolled body It is uncontrolled bo	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L LIDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345492	B. WING _			C 11/04/2022
	ROVIDER OR SUPPLIER	YETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301		1 11/04/2022
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		BE COMPLETION
F 580	Practitioner) notified nursing to assure resthinners and if not to resident. Resident 's stopped at roughly 2 abrasion to left face reported to be from a daughter (name of dwas unable to be reacall. Resident 's daughter (name of dwas unable to be reacall. Resident 's daughter (see CT scan and she stanecessary then she of the physician had be and ordered that the hospital emergency of NA (Nurse Aide # 1) assigned dayshift NA interviewed on 11/2/2 Resident # 3 had fall and Nurse # 2 had gobserved he had fall Nurse # 2 was intervand reported the follog/27/22, she had gor and observed his leg bed and resting on the was in the bed, and getting his legs back time, NA # 1 had appher Resident # 3 kephad instructed NA #	ncrease anxiety. NP (Nurse at 12:30 PM and advised sident wasn ' t on any blood just continue to monitor is nose bleed was able to be :15 PM. Resident has an and a skin tear to left elbow a recent fall. Resident ' s aughter) notified however ached. VM (voice mail) left for ighter was contacted on and was notified of incident. It is daughter if she would like a stes that if the MD feels it would. MD notified."  2M an entry was made noting the into see Resident # 3 resident be sent to the department.  A on 9/27/22. NA # 1 was 22 at 1:50 PM and reported en the morning of 9/27/22 one in the room and	F 5	80		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(	С
		345492	B. WING		<del></del>	11/	04/2022
NAME OF P	ROVIDER OR SUPPLIER	•	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
		V		2	214 COCHRAN AVENUE		
NC STATE	VETERANS HOME - FA	YETTEVILLE		F	FAYETTEVILLE, NC 28301		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 580	Continued From page	e 5	F	580			
		t the nursing desk where	'	000			
	-	more closely. NA # 1 did not					
	_						
	had not gone in the re	ad fallen and she (Nurse # 2)					
	observed that the res						
	Approximately 20 mir	oring the resident to the					
		er monitoring, she observed					
	•	s at the nursing desk and he					
		to his movement. Shortly					
	_	t the nursing desk, she					
		se was bleeding. The nursing					
		B) was present and they both					
		olying ice and pressure to get					
		They called the on call					
		ose bleed and the provided					
	•	ake sure he was not on an					
	anticoagulant. She di	id not inform the on call					
	_	dent had fallen because she					
	· · ·	d fallen. The bleeding					
		subsided. The resident did					
		nt bruises during her shift.					
		neck abrasion which looked					
	like a "rug burn" and	a small skin tear to his left					
	elbow. She had talke	d to the nursing supervisor					
	(Nurse # 3), who let h	ner know he had fallen					
	previously and it was	felt those two areas were					
	from his constant mo	vements possibly reopening					
	them. He kept picking	g at the one on his face and					
	therefore it was plaus	sible to her that they were old					
		ned. If she had known he					
		have communicated this to					
	the physician. The ne	ext day she learned there					
	was an investigation						
	administrative staff be	ecause bruises had					
	appeared on his face	on the shift following her					
	dayshift of 9/27/22. A	•					
		nembers on 9/28/22 along					
		eported Resident # 3 had				l	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345492	B. WING		1	C 1/04/2022	
	ROVIDER OR SUPPLIER  VETERANS HOME -	FAYETTEVILLE		STREET ADDRESS, CITY, STATE, 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 580	first time she had had fallen.  Nurse # 3 was into via phone and rep worked as the day 9/27/22. Around lu observed Residen desk. He was hav refusing to eat. He she thought was chad reported to he Nurse # 2 worked and after it did not minutes, they called the nose bleed. It provider that the none had made her Nurse # 1 had been to 11 PM shift on sinterviewed on 11/2 the following. She ADON (Assistant I medication nurse laceration to his chad there was "not bad." It was non him a second to point, the bruising	age 6 ing of 9/27/22. That was the been made aware Resident # 3 erviewed on 11/2/22 at 8:30 PM orted the following. She had a shift facility supervisor on such time on 9/27/22 she had at # 3 in a chair at the nursing ing a nose bleed and was also had a check wound which old and had reopened. No one er that he had fallen. She and to try to get the bleeding to stop a stop for about 30 to 40 and the on call provider to report was not reported to the on call esident had fallen because no aware Resident # 3 had fallen.  The supervisor for the 3 PM and reported had been informed by the Director of Nursing) and that Resident # 3 had a neek. She checked on him near fit and saw the laceration. It was as a small bruise which was ear his jaw bone. She checked ime during her shift and at that had worsened. At this second to think that the bruising was	F	580	JENCY)		
	more significant the caused by the smatalked to the direct Director of Nursing inform them about	an what would have been all laceration on his check. She t care nurse. She did call the g and the on call provider and the bruising, but she did not					

NAME OF PROVIDER OR SUPPLIER  NC STATE VETERANS HOME - FAYETTEVILLE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301  PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION)	•	C // <b>04/2022</b>
NC STATE VETERANS HOME - FAYETTEVILLE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	- PREFIX	214 COCHRAN AVENUE FAYETTEVILLE, NC 28301 PROVIDER'S PLAN OF COR	•	10-1/2022
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	- PREFIX			
		CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
he had fallen. At the time, although the bruisin was worsening, Resident # 3 was resting comfortably and the decision was made not to send him out at that point.  A review of the physician 's progress note, da 9/28/22 revealed the following notation, "I was called today by the nursing staff to see (Resid #3) who sustained a fall from standing positior yesterdayHe has obvious left facial trauma These is a small cut over the left zygom (chec bone). There is left periorbital ecchymosis (bruising around the eye) with tenderness and swelling, left cheek tenderness and swelling, a large 10 cm (centimeter) area of bruising over left lower face and mandible (jaw bone). The leglob. (as written) He said he can see me in fro of him. He appears in pain and weakI belie he has multiple facial fractures, an infraorbital fracture and mandible fracture."  According to the nursing notes, Resident # 3 v transferred to the hospital on 9/28/22 at 4:51 F.  Hospital records for the date of 9/28/22 reveal Resident # 3 had a CT (a computerized tomography scan) of his face which showed fractures of multiple bones in his face; includin fracture of the medial wall of the left maxillary sinus, fracture of the left mandible, fracture of lateral pterygoid process (which allows the	ted ent n a. k the eft ent ve	,		
jawbone to move while eating), fracture of the lateral orbital rim and lateral orbital wall. The resident was transferred back to the facility for care on 9/30/22.  Resident # 3 's physician, who serves as the facility's medical director, was interviewed, on 11/3/22 at 12:11 PM and reported the following				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED	
		345492	B. WING _			C 11/04/2022	
	ROVIDER OR SUPPLIER	YETTEVILLE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301		1110-112022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIAT DEFICIENCY)	5475	
F 580	She assessed the restell from visually looking fractured his facial botaken a direct hard his facility staff had told to 9/27/22 about the fall have been transferred. On 11/2/22 at 1:05 Pl Nursing presented and # 3's fall. According to thought the bruise was movements and it was administrative staff the 9/28/22. They started on 9/28/22 and at that the resident had falled. The Administrator was 10:40 AM and reported 9/28/22 that there had communication between the staff had physician would have always told the province Administrator stated to complete plan of corranalysis regarding the presented the plan of the presented the plan of the staff had presented the plan of the presented the plan of the presented the plan of the staff had presented the plan of the plan of the presented the plan of the presented the plan of the plan	sident on 9/28/22 and could ng at him that he had nes. It appeared he had to his check area. If the he on call provider on then the resident would dout that day.  If the Assistant Director of a investigation into Resident to the ADON, initially it was as from the resident's own so not made clear to at he had fallen until to investigate the incident to point it was reported that the point it was reported that not so interviewed on 11/3/22 at a ded that they identified on the been a lack of the investigation, staff afferent scenarios; with Nurse never had been told the ad with NA # 1 reporting that the esident had fallen. According if the communication is occurred correctly then the interval in the selection of the course	F	580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345492	B. WING		C 11/04/2022
	ROVIDER OR SUPPLIER	FAYETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301	1110412022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 580	bruises on his face, and ordered to go ton 9.28.22.  b. Root Cause Analthe Assistant Direct Administrator. The that the nurse was nursing assistant the down on the floor bean Analysis was composted.  Step 2.  a. All residents have bean All falls from 9.28 reviewed by the Cacommunication to the significant changes revealed that the Monotified of each fall, place that limit the president was assessed.  Step 3.  a. 10.20-22 - Education Resistant Director of the significant changes revealed that the Monotified of each fall, place that limit the president was assessed.	assessed by the nurse due to then assessed by the MD of the local Emergency Room by the local Emergency By the loca	F 58		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345492	B. WING			11/	04/2022
	ROVIDER OR SUPPLIER  VETERANS HOME - FAY	YETTEVILLE		2	TREET ADDRESS, CITY, STATE, ZIP CODE  14 COCHRAN AVENUE  AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Certified Nursing Assileaving off shift to concondition, (ex. Falls, sconcerns.  b. 10.28.22 - Addition education to all licens communication to the Practitioner, provided by the Assistant Director Nursing. New staff upon hire, annually, a Step 4.  a. 10.28.22 - Monitorichanges in condition, the Medical Director/Nishift rounding checklis Director of Nursing and Nursing.  Monitoring will occur sweeks, then 2 times pronthly for 3 months with tracking and trendirector of Nursing (RN) monthly Performance Improversecommendations and improvements and checklis Completion date 10.2	A Shift Report is for the stant coming on shift and numicate any changes in skin tear, etc), and any other ally, included in the ed nurses was Medical Director/Nurse detor of Nursing and Director will continue to be educated and as needed.  In go f communication of falls and communication to Nurse Practitioner using the st will be done by the and Assistant Director of times per week for 4 weeks, and Results of the monitoring, ding, will be reported by the ement committee for desuggestions for anges.	F	580			

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		345492	B. WING _			l	C <b>04/2022</b>
	ROVIDER OR SUPPLIER	YETTEVILLE		214 CO	ADDRESS, CITY, STATE, ZIP CODE CHRAN AVENUE FEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	education. It was four been completed per t correction.  The facility presented found the facility had their plan of correction.  Multiple staff member 11/3/22 and reported regarding reporting cl physician. The facility of the rounding sheet were being completed	l evidence of inservice and inservice education had the facility 's plan of l evidence of audits. It was been conducting audits per n.  The were interviewed on they had received education hanges of condition to the vistaff were knowledgeable and reported the sheets diet at end of shift to assure being conducted about	F	580			
F 684 SS=J	11/4/22 at 3:05 PM ar There had been no of was aware where fac change in condition o Nurse Practitioners. T the facility staff had h very good about callin The facility's credible was validated for the Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatment facility residents. Bas	allegation of compliance date of 10/29/22.	F(	584			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRU			PLETED
		345492	B. WING _				C <b>04/2022</b>
	ROVIDER OR SUPPLIER	/ETTEVILLE	•	214 COCHE	DRESS, CITY, STATE, ZIP CODE RAN AVENUE VILLE, NC 28301	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 684	accordance with profer practice, the compreher care plan, and the rest This REQUIREMENT by: Based on record reviphysician interview for sampled residents where the facility failed to confallen in order that the assessments, neuroloid directly following the front to the hospital the was identified to have which included a fract maxillary sinus (near mandible (the jawbon pterygoid process (whomove while eating), a orbital rim and lateral the eye).  The findings included  Resident # 3 resided until 10/21/22. Resided in part Parkinsons, Litremors, and chorea I movements (jerky moneurological disorder)  Resident # 3's Minimudated 8/16/22, coded complete the interview also coded as needin	treatment and care in essional standards of ensive person-centered sidents' choices.  is not met as evidenced  ew, staff interview, and rone (Resident # 3) of three to experienced accidents, mmunicate the resident had experienced accidents, estall. The resident was sent day following the fall and exputiple facial fractures ture of the wall of the left the nose), fracture of the left ep), fracture of the lateral nich allows the jawbone to and fracture of the left lateral orbital wall (bones around)  at the facility from 11/5/21 ent # 3's diagnoses included ewy Body Dementia, ike uncontrolled body verments caused by a lateral orbital wall to work a service of the was gextensive assistance with ene. He was also coded as	F	Past	noncompliance: no plan of ction required.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	AYETTEVILLE		STREET ADDRESS, CITY, STATE, 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)	DATE
F 684	Resident # 3 was at of falls. This was add 11/5/21 and remained care plan up until his According to hospital hospitalized from 9/4 to an altered mental time, the resident un Following his 9/16/22 Resident # 3 was trafor care with hospiced Review of nursing not first entry was entered wrote at that time, "u (continues) with uncontinues) with uncontinues and ADON (Ast that resident has brulaceration to left check is cheek because of movements. He is not along left jaw line. He pain. DOHS (Director provider notified."  The next nursing entered and the service of the servic	plan included information that risk for falls and had a history ded to the care plan on d as an active part of his discharge date.  I records the resident was 4/22 until 9/16/22 secondary status change. During this derwent cranial surgery. 2 hospital discharge, insferred back to the facility eservices.  otes for 9/27/22 revealed the ed at 6:28 PM. Nurse # 1	F6	584		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345492	B. WING _			C <b>11/04/2022</b>	
	ROVIDER OR SUPPLIER  VETERANS HOME - FA	YETTEVILLE	•	STREET ADDRESS, CITY, STATE, ZIP ( 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIA		N
F 684	s/sx (signs and symposts) The next nursing ent 3:04 PM as a "late en noted the following." 9/27/22 in room at 9:000 his right side with body on his bed and mat with the bed in the was assisted back up CNA (certified nursin resident had been most stand unassisted. Nuresident into chair so closer by nursing staresident present with combative and has in Practitioner) notified nursing to assure resthinners and if not to resident. Resident's stopped at roughly 2 abrasion to left face a reported to be from a daughter (name of daughter (name of daughter (name of daughter (name of daughter) and be reacall. Resident's daughter (name of daughter) and she stanecessary then she was no indicated neurological checks on 9/27/22.  On 9/28/22 at 4:21 P.	left mandible. Monitoring for stoms) of discomfort."  ry was made on 9/28/22 at htry" by Nurse # 2. Nurse # 2 Resident was observed on 45 AM by this writer. Lying the right upper part of his his lower half on the floor he lowest position. Resident to on to his bed. At 12:00 g assistant) reported that aking several attempts to urse advised CNA to assist that he could be monitored ff for safety. At 12:25 PM a nose bleed. Resident also increase anxiety. NP (Nurse at 12:30 PM and advised sident wasn't on any blood just continue to monitor hose bleed was able to be at 5 PM. Resident has an and a skin tear to left elbow a recent fall. Resident's aughter) notified however to ched. VM (voice mail) left for ghter was contacted on and was notified of incident.  daughter if she would like a tes that if the MD feels it would. MD notified."	Fé	584			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY  COMPLETED
		345492	B. WING _			C 11/04/2022
	ROVIDER OR SUPPLIER	YETTEVILLE	,	STREET ADDRESS, CITY, STATE, Z 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301	IP CODE	11/04/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE CROSS-REFERENCED DEFICE)	ACTION SHOULD BE TO THE APPROPRIA	DATE
F 684	NA (Nurse Aide # 1) assigned dayshift NA interviewed on 11/2/2 the following. On the was in his room in the bed. The bed was in floor. Nurse # 2 had at the bed, had assisted had told her to keep. She was aware Residente low bed. He had and after cleaning hir to let her know. They and found that he had as if he was trying to and with his face poing ground. He had a cubruising. Nurse # 2 was interefore she (NA # pick the resident up a did so. She then took Later his nose started reported he did not he fall of which she was Nurse # 2 was interviand reported the followare when she took 9/27/22 that he had he during his hospitalizat That information had nursing report. On the had gone by Resider his legs were flopped resting on the floor metals.	resident be sent to the department.  had been Resident # 3 ' s at on 9/27/22. NA # 1 was 22 at 1:50 PM and reported AM of 9/27/22 Resident # 3 be bed with a mat beside his the low position near the seen him earlier part way off the him back into the bed, and checking on him. She did so dent # 3 could stand up from some diarrhea that morning m, she went to get Nurse # 2 both went back to the room different and hold himself up off the floor need down towards the ston his cheek and no was pregnant at the time and 10 told Nurse # 2 she would and put him in his chair. She is him to the nursing desk. It do bleed that day. NA # 1 ave any head injury from the	F6	584		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345492	B. WING				04/2022
NAME OF PI	ROVIDER OR SUPPLIER		ı	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1	•
				2	214 COCHRAN AVENUE		
NC STATE	VETERANS HOME - FA	YETTEVILLE		F	FAYETTEVILLE, NC 28301		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLÉTION DATE
F 684	Continued From page	e 16	F	684			
		Around lunch time, NA#1					
	•	and informed her Resident#					
	1	ut of bed. She had instructed					
	. , , ,	nelp of another NA, assist					
		chair, and then place him at					
	the nursing desk whe	ere they could watch him					
	more closely. NA#1	did not report the resident					
	,	lurse # 2) had not gone in					
	the room with NA # 1 and observed that the						
	resident had fallen. Approximately 20 minutes						
	after she had instructed NA # 1 to bring the						
	resident to the nursing desk for closer monitoring, she observed that Resident # 3 was at the						
		had a rocking motion to his					
	_	ofter observing him at the					
	-	served that his nose was					
		g supervisor (Nurse # 3) was					
		h tried to work with applying					
		et the bleeding to stop. They					
		vider who instructed them to					
	make sure he was no	ot on an anticoagulant. She					
	did not inform the on	call provider that the					
		that he had a history of					
		use she had not known either					
	l	erself. The bleeding slowed					
		d. The resident did not have					
		during her shift. He had a					
		sion which looked like a "rug n tear to his left elbow. She					
		sing supervisor (Nurse # 3),					
		had fallen previously and it					
		eas were from his constant					
		reopening them. He kept					
		his face and therefore it was					
	ı · •	hey were old areas that had					
	I *	d a steri strip on his cheek					
		placed a protected dressing					
	to his elbow. If she ha	ad known he had fallen she					
	would have communi	icated this to the physician.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(	(X3) DATE SURVEY COMPLETED	
		345492	B. WING _			C <b>11/04/2022</b>	
	ROVIDER OR SUPPLIER	AYETTEVILLE	•	STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIAT	DATE	
F 684	because bruises has shift following her datalking to administra 9/28/22 along with Nesident # 3 had fal and at one point dur reported the resident the morning of 9/27/2 the first time NA # 1 resident had fallen of the morning of 9/27/2 the first time NA # 1 resident had fallen of the morning of 9/27/2 the first time NA # 1 resident had fallen of the morning of 9/27/2 the first time NA # 1 resident had fallen of the morning of 9/27/2 the first time NA # 1 resident had fallen of the worked as the day s 9/27/22. Around lun observed Resident a she thought was having refusing to eat. He as thought was old had reported to her Nurse # 2 worked to and after it did not sminutes, they called facility nursing expended fallen and hit the an unwitnessed fall neurological checks had not been done I neither of them knew They were able to enother on the data observe any bruising was made aware the bruises.	arned there was an a care by administrative staff of appeared on his face on the ayshift of 9/27/22. As she was attive staff members on NA # 1, NA # 1 reported allen on the morning of 9/27/22 ring the investigation, NA # 1 at had fallen multiple times on 1/22. The date of 9/28/22 was had reported that the on 9/27/22.  Aviewed on 11/2/22 at 8:30 PM attended the following. She had shift facility supervisor on the time on 9/27/22 she had # 3 in a chair at the nursing g a nose bleed and was also had a cheek wound which and had reopened. No one that he had fallen. She and the try to get the bleeding to stop top for about 30 to 40. The on call provider. It was a ctation that a resident who eir head or had experienced	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345492	B. WING _			C 1/04/2022	
	ROVIDER OR SUPPLIER	FAYETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP C 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF  (EACH CORRECTIVE ACT  CROSS-REFERENCED TO T  DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	interviewed on 11/ the following. She ADON (Assistant I medication nurse is laceration to his of the first of the shift small and there wa "not bad." It was n on him a second ti point, the bruising check, she began more significant the caused by the small talked to the direct the direct care nur because there had He did have a hist was plausible to he face on something Nursing and the or about the bruising comfortably and the send him out at the A review of the ph 9/28/22 revealed to called today by the #3) who sustained yesterdayHe he These is a small of bone). There is lef (bruising around the swelling, left cheel large 10 cm (centil left lower face and glob. (as written) Ho of him. He appear	2/27/22. Nurse # 1 was 2/2/22 at 4:10 PM and reported 2 had been informed by the Director of Nursing) and that Resident # 3 had a neek. She checked on him at t and saw the laceration. It was as a small bruise which was ear his jaw bone. She checked ime during her shift and at that had worsened. At this second to think that the bruising was han what would have been all laceration on his check. She t care nurse. Neither she nor rese did any neuro checks d been no reported falls for him. ory of constantly moving and it er that he had still bumped his g. She did call the Director of in call provider and inform them . At the time, he was resting the decision was made not to	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345492	B. WING _			l	C <b>04/2022</b>
	ROVIDER OR SUPPLIER	YETTEVILLE	·	STREET ADDRESS, CITY, STATE, ZIP CO 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE
F 684	transferred to the hose Hospital records for the Resident # 3 had a Comography scan) of fractures of multiple is fracture of the medial sinus, fracture of the lateral pterygoid proof jawbone to move while lateral orbital rim and resident was transfer care on 9/30/22.  Resident # 3 's phys facility 's medical direction of the lateral orbital rim and resident was transfer care on 9/30/22.  Resident # 3 's phys facility 's medical direction visually look fractured his facial bot taken a direct hard his facility staff had told to 9/27/22 about the fall have been transferre.  On 11/2/22 at 1:05 Phoursing presented ar # 3 's fall. According thought the bruise was movements and it was administrative staff the 9/28/22. They started on 9/28/22 and at that the resident had faller.	sing notes, Resident # 3 was spital on 9/28/22 at 4:51 PM.  The date of 9/28/22 revealed CT (a computerized his face which showed cones in his face; including I wall of the left maxillary left mandible, fracture of the cess (which allows the idle eating), fracture of the left I lateral orbital wall. The cred back to the facility for sident, who serves as the ector, was interviewed, on and reported the following. Sident on 9/28/22 and could ing at him that he had cones. It appeared he had it to his check area. If the the on call provider on I, then the resident would do ut that day for evaluation.  M the Assistant Director of in investigation into Resident to the ADON, initially it was as from the resident's own as not made clear to nat he had fallen until I to investigate the incident at point it was reported that	F6	584			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345492	B. WING _			C 11/04/2022
	ROVIDER OR SUPPLIER	YETTEVILLE		STREET ADDRESS, CITY, STATE, 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301	ZIP CODE	11/04/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		
F 684	9/28/22 that there had communication betwee resident's fall. During members reported diff # 2 reporting that she resident had fallen ar she had reported the Administrator, if the costaff had occurred cowould have been assign injuries. The Adminad done a complete root cause analysis. The plan of correction On 11/3/22 the facility of immediate jeopard POC for Communication condition/Falls  Step 1.  Resident #3 was assigned by the services on his face, the and ordered to go to so on 9.28.22.  Root Cause Analysis the Assistant Director Administrator. The Resident the nurse was no nursing assistant that	ed that they identified on d been a lack of een her staff about the the investigation, staff afferent scenarios; with Nurse never had been told the ad with NA # 1 reporting that fall. According to the communication between her rectly then the resident essed on the day of the fall nistrator stated the facility plan of correction with a The Administrator presented as follows.  Administrator was notified by.  The Administrator was notified by.	F	584		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345492	B. WING			C 11/04/2022
	ROVIDER OR SUPPLIER  E VETERANS HOME -	FAYETTEVILLE		STREET ADDRESS, 214 COCHRAN AVE FAYETTEVILLE,		,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	OVIDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETION
F 684	All falls from 9.29.2 by the Case Mix D communication be events and circum and for identifying of fall; and ensure assessed by a nur Medical Director haintervention were palling, and each renurse.  Step 3.  10.20-22 - Educati Nursing Assistants Director on communication using the shift rour Nursing Assistants Shift Report is for a coming on shift and communicate any Falls, skin tear, etc.  10.20.22 - Educati assessment by a murses; New staff upon hire, annually Step 4.  10.28.22 - Monitor changes in condition the Medical Director checklist, and ensured the communication and the medical director checklist, and ensured the mixed the communication and the medical director checklist, and ensured the mixed the condition of the medical director checklist, and ensured the communication and the mixed the condition of the medical director checklist, and ensured the communication and the mixed the condition of the mixed the communication and	the potential to be affected.  22 to 10.15.22 were reviewed irector to ensure tween parties for identifying the stances that resulted in the fall interventions that limit the risk all residents with falls were se. The audit revealed that the ad been notified of each fall, but in place that limit the risk of esident was assessed by a  on was done for all Certified and Licensed Nurses by the of Nursing for the nursing staff of changes in condition/falls, ading checklist for Certified and Charge Nurses. C.N.A he Certified Nursing Assistant d leaving off shift to changes in condition, (ex. e), and any other concerns.  on included the importance of urse after a fall for all licensed will continue to be educated	F	584		

PRINTED: 11/10/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345492	B. WING			l	C <b>04/2022</b>
	ROVIDER OR SUPPLIER	YETTEVILLE	•	214	REET ADDRESS, CITY, STATE, ZIP CODE 4 COCHRAN AVENUE YETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Monitoring will occur weeks, then 2 times p monthly for 3 months with tracking and tren Director of Nursing (F	5 times per week for 4 per week for 4 weeks, and Results of the monitoring, ading, will be reported by RN) and Assistant Director of to the Quality Assurance ement committee for d suggestions for manges.	F	684			
	The facility presented education. It was four been completed per to correction.  The facility presented found the facility had their plan of correction.  Multiple staff member 11/3/22 and reported regarding reporting a falls and medical conwere knowledgeable reported the sheets wo fishift to assure commonducted about characterists.	d evidence of inservice and inservice education had the facility 's plan of devidence of audits. It was been conducting audits per n.  The swere interviewed on they had received education assuring education of ditions. The facility staff of the rounding sheets and were being completed at end inmunication was being					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ı	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345492	B. WING _			C I <b>1/04/2022</b>
	ROVIDER OR SUPPLIER  E VETERANS HOME - FA	YETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	between the time of 1 Residents reported th nursing care. A family on 11/3/22 at 12:55 P pleased with nursing Review of the medica who had experienced staff were providing a	0:30 AM to 12:00 PM. ney were pleased with member was interviewed M and reported they were care. If records of other residents, accidents, revealed nursing	F	584		